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May 28, 2010

The Honorable Valerie Wiener
3540 West Sahara, #352
Las Vegas, NV 89102-5816

Dear Senator Wiener:

As you may know, Senate Bill 319 of the 2009 Legislative Session directed the Health Division to study the feasibility of tracking and reporting near-miss events as part of the reports of sentinel events and to define the term "near-miss event." Please find enclosed the final report for your review. The study and report were coordinated by Leticia Metherell, RN, BSN, Health Facilities Surveyor IV, on behalf of the Division.

The Near Miss study group met on the following dates: October 23, 2009; December 8, 2009; January 26, 2010; and February 23, 2010. The group included participation from representatives of the Nevada Ambulatory Surgery Center Association, the Nevada Hospital Association, a patient/consumer advocate and large payer/purchaser, Health Insight – Nevada's Quality Improvement Organization (QIO), the Nevada State Medical Association, ambulatory surgical centers, hospitals and Health Division employees.

The study group found that a "near-miss concept" is already contained in statutes within the definition of a sentinel event. NRS 439.830 defines a sentinel event as:

> . . . an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function. [Emphasis added.]

This definition incorporates an actual event with actual harm as well as "the risk [ ] of . . . any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." The study revealed that facilities have been reporting both types of events to the Sentinel Events Registry, actual sentinel events; and "risk of" events.

In addition, as you may know the passage of AB 206 from the 2009 Legislative Session authorizes the imposition of an administrative sanction to a medical facility that fails to submit a report of a sentinel

event as defined by NRS 439.830. Therefore, under the current sentinel event definition, a facility can be fined for not reporting a "risk of" event.

To help clarify the definition of a sentinel event, the Near Miss study group recommends that the definition in statutes should be evaluated to provide separate, clear definitions for an actual event and for a near miss or "risk of" event using nationally recognized definitions, such as those used by the United States Department of Health and Human Services Agency for Healthcare Research and Quality.

In conclusion, a separate near miss definition should not be adopted while the sentinel event definition in statutes contains a near miss concept and the sentinel event definition in statutes should be evaluated to provide separate, clear definitions for a sentinel event and for a near miss.

If you have additional questions or concerns, please feel free to direct them to Ms. Metherell at 775-687-4475, ext. 235.

Sincerely,

Richard Whitley, MS
Administrator

cc: Tracey Green, MD, State Health Officer
Leticia Metherell, Health Division, Bureau of Health Care Quality and Compliance

Near Miss Study Proposal – Background Documentation

This document describes issues considered pursuant to Senate Bill 319 of the 2009 Legislative Session. This measure required the Health Division, with a designated set of participants, to "study the feasibility of tracking and reporting near miss events as part of the reports of sentinel events pursuant to NRS 439.835, including, without limitation, defining the term 'near-miss event,' investigating a manner for tracking near-miss events and determining the feasibility of reporting near-miss events."

Background

In considering the feasibility of defining a "near miss event," the existing definition for a sentinel event was reviewed:

> **NRS 439.830 "Sentinel event" defined.** "Sentinel event" means an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or *the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.* The term includes loss of limb or function. [Emphasis added.]
> (Added to NRS by 2002 Special Session, 13; A 2005, 599)

The Sentinel event definition currently in statutes has a near miss component contained in the definition: the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

The study group also considered relevant definitions from other nationally recognized organizations and other states include as noted below:

1. **The US DHHS – Agency for Health Care Research and Quality (AHRQ)** coordinates the development of Common Formats for event reporting to Patient Safety Organizations. The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) and the Patient Safety and Quality Improvement Final Rule (Patient Safety Rule) authorize these activities. According to the AHRQ Common Formats, **near misses or close calls** are defined as patient safety events that did not reach the patient.

2. **World Health Organization's definition: "Near miss" or "close call":** a serious error or mishap that has the potential to cause an adverse event, but fails to do so by chance or because it was intercepted.

3. **The Institute for Safe Medication Practice** defines a **"Close call (near miss)"** as: An event, situation, or error that took place but was captured before reaching the patient.

4. **Vermont: "Near Miss"** means any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

5. **New York**: **"Near Misses"** are those events that might have resulted in harm to a patient but were discovered and corrected before they ever reached the patient.

6. **Oregon**: **"Near Miss"** – the event did not reach the patient.

7. **Pennsylvania** identifies a near miss as an incident. **"Incident":** An event, occurrence or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a serious event (sentinel event).

8. **Maine: "Near Miss"** means an event or situation that did not produce patient injury, but only because of chance, which may include, but is not limited to, robustness of the patient or a fortuitous, timely intervention.

9. **New Jersey: "Near Miss"** means an occurrence that could have resulted in an adverse event but the adverse event was prevented.

10. **Washington: "Incident"** means an event, occurrence, or situation involving the clinical care of a patient in a medical facility that:

    (a) Results in unanticipated injury to a patient that is not related to the natural course of the patient's illness or underlying condition and does not constitute an adverse event; or

    (b) Could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient.

11. **Kansas: "Reportable incident"** means an act by a health care provider which:

    (1) Is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient; or

    (2) May be grounds for disciplinary action by the appropriate licensing agency.

12. **Florida: a near miss is defined** as any potentially harmful event that could have had an adverse result; but, through chance or intervention, harm was prevented.

Analysis

Although Nevada's definition for a sentinel event requires reporting of "risk of" events, it does not clearly delineate between a "sentinel event" and a "near miss" or "risk of" event. Further, it is clear that other states distinguish between sentinel events and near miss events. Any of the preceding definitions may be considered as a definition for "near miss" separate and distinct from "sentinel event" as defined by NRS 439.830.

As to reporting these events, once a definition is clear, the system is already in place to collect both sentinel events and near miss events; therefore, it is feasible in Nevada to track near miss events.

Recommendations by the Study Group

The members of the study group recognize that the definition in statutes for "sentinel event" should be evaluated to provide separate, clear definitions for an actual event and for a near miss or "risk of" event using nationally recognized definitions, such as those used by the United States Department of Health and Human Services Agency for Healthcare Research and Quality.

In addition, if the Legislature determines a need to report and track near miss events, members of the study group recommend that a near miss should be:

1. Voluntarily reported, not sanctioned for failure to report; and

2. Confidential.